June 30, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1200-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient is approximately 46 years of age and lives in ___. ___ sustained a work-related injury on ___ when she twisted, stooped to get a box and reportedly felt pain in her low back. A later diagnosis was primarily that of a soft tissue injury.

She had an MRI that revealed mild to moderate lumbar DJD findings, usual in her age group. Since that time she has had extensive medical treatment including multiple epidural injections. Her response to treatment has been quit poor. Functional overlay was significantly evident in one examination in February 2002. (And at that time she was also complaining of headaches, neck pain, shoulder pain, upper mid, and lower spine pain, as well as pain in both lower extremities.

She had the MRI study and also the relatively non-remarkable electrodiagnostic studies.

She has an ongoing subjective medical pain syndrome.

Her physician in September, 2002 reported poor response with conservative management. The patient reportedly "failed physical therapy" and had "exhausted all treatment options for conservative management." She did not have a surgical-type problem.

An interferential stimulator is one of many types of passive modalities, and it has been utilized. At this time, the purchase for permanent use has been requested.

REQUESTED SERVICE

The purchase of an RS4i sequential stimulator, a four-channel combination muscle stimulator and interferential unit, is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer does not find that the purchase of the interferential neuromuscular stimulator is indicated in this case, at this late date in her history. These devices are indicated for more acute pain situations. There is no good medical evidence or literature known by the reviewer that can justify this item, nor that would indicate likelihood of sustained benefit or medical improvement with this device, with comparison to any other palliative modalities and a daily proper exercise program.

This case is now almost two years post-diagnosis of a soft tissue strain. She has had minimal improvement with all the various medical modalities tried. Also, on certain examinations, she has had well-documented evidence of a large component of functional overlay, and non-physiological-type responses on her physical examination with symptoms that are very much out of proportion to her actual objective/physical findings.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 30th day of June 2003.